Annual Report to

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

on

Deaths Reported and Facility Compliance with Restraints and Seclusion

as originally required by SL 2000-129, Section 3(b), 5(b) and 6(b)
and as amended by SL 2003-58, Sections 1-4

Submitted by
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
and Division of Facility Services
Department of Health and Human Services

Prepared by
Quality Management Team
Community Policy Management Section
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

September 1, 2005

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INTRODUCTION

Section 3(b), 5(b) and 6(b) of Session Law 2000-129 (HB 1520), as amended by Sections 1-4 of Session Law 2003-58 (HB 80), requires the Department of Health and Human Services to report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services on the following for the immediately preceding fiscal year:

- The total number of facilities that reported deaths under G.S. 122C-31, G.S. 131D-10.6, and G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to these statutes, and the number found by the investigation to be related to the use of restraint or seclusion.
- The level of compliance of certain facilities with applicable State and federal laws, rules, and regulations governing the use of restraints and seclusion. The information shall include areas of highest and lowest levels of compliance.

Outlined in the succeeding pages is a compilation of the data provided by these facilities in addition to deficiency information gleaned from monitoring reports, surveys and investigations conducted by Department staff. **This data covers the period of July 1, 2004 through June 30, 2005.**

DEATHS REPORTED

Session Law 2000-129 amended G.S. 122C-31, 131D-10.6B and 131D-34.1 by requiring certain facilities to notify the Department of Health and Human Services of any death of a consumer:

- Occurring within seven days of use of physical restraint or physical hold; or
- Resulting from violence, accident, suicide or homicide.

10A NCAC 26C Section .0300 implement the death reporting requirements of these laws and provide specific instructions to facilities for reporting deaths.

- **Facilities licensed** in accordance with G.S. 122C, Article 2, **State facilities** operating in accordance with G.S. 122C Article 4, Part 5 and **inpatient psychiatric units** of hospitals licensed under G.S. 131E shall report client deaths to the **Division of Facility Services**.
- **Facilities not licensed** in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5 shall report client deaths to the **Division of Mental Health, Developmental Disabilities, and Substance Abuse Services**.

All deaths reported to the Department are screened to determine if an investigation is warranted. The primary purpose of the screening and any subsequent investigation is to determine if the facility was culpable in the consumer's death. For purposes of this report, the outcome of the investigation is limited to whether the death occurred as a result of restraint, physical hold, or seclusion.

The following seven tables depict each facility that reported one or more deaths for the time period beginning July 1, 2004 and ending June 30, 2005. Each table identifies the number of deaths reported and screened, deaths investigated and the number found by the investigation to be a result of the facility's use of physical restraint, physical hold, or seclusion. If a facility is not listed, a death was not reported to the Department.

DEATHS REPORTED BY PRIVATE FACILITIES

The first five tables provide data submitted by private facilities regarding deaths that were subject to the reporting requirements in G.S. 122C-31, 131D-10.6B and 131D-34.1, namely deaths that occurred within seven days of restraint, physical hold, or seclusion, or that were the result of violence, accident, suicide or homicide. These tables do not include deaths that were voluntarily reported to the Department that were the result of other causes. It should be noted that all deaths that were reported were screened and investigated when circumstances warranted it. Summary information about other deaths that were voluntarily reported to the Department are provided after each table.

Private Facilities: Licensed Assisted Living Facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Investigated and Death was due to Restraint/Hold[3]
Alexander	Belle's View Adult Care	1	0	
Beaufort	Washington Manor	1	0	
Bladen	Bridgers Family Care	1	1	
Buncombe	Mt. Pisgah Family Care	1	0	
Burke	Grace Ridge	1	1	
Carteret	Carolina House of Morehead City	1	0	
Edgecombe	Heritage Retirement Center	1	1	
Forsyth	Creekside Manor	1	1	
	Dushane Family Care Home	1	1	
Gaston	Gaston Place	1	1	
Guilford	High Point Manor	1	0	
	Arbor Care Assisted Living	1	0	
	Oakdale Heights Senior Living	1	1	
	Greensboro Place	1	0	
Iredell	Crown Colony	1	0	
	Heritage Place	1	1	
	Discovery Program at Statesville	2	1	
Martin	Vintage Inn	1	0	
McDowell	Houston House	1	0	
Montgomery	Starmount Assisted Living	1	0	
New Hanover	Hermitage House	1	1	
	Judge Family Care Home #4	1	0	
	Port South Village/Carmen D Villa	1	1	
Randolph	Tru-Care of Archdale	1	1	
	Brookstone Haven	1	0	
Scotland	Meadows of Laurinburg	1	1	
Stokes	Rose Tara Plantation	1	0	
Wake	Meadows of Garner	1	1	
	The Oliver House	1	1	

Private Facilities: Licensed Assisted Living Facilities[1] (Continued)

County	Facility	# Deaths Reported and Screened	# Reports Investigated[2]	# Investigated and Death was due to Restraint/Hold[3]
Wilkes	Mountain House Assisted Living	1	1	
Wilson	Friendly Elm Assisted Living	1	1	
Total		**32**	**17**	**0**

NOTES:

1. There were 1,295 Licensed Assisted Living Facilities with a total of 35,969 of beds.
2. For licensed assisted living facilities, the investigation is initiated by a referral of the death report to the Adult Care Licensure Section of DFS and the County Department of Social Services by the DFS Complaint Intake Unit after screening for compliance issues.
3. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

A number of licensed assisted living facilities voluntarily reported deaths that were not subject to G.S. 131D-34.1. For the period beginning July 1, 2004 and ending June 30, 2005, 24 facilities reported 40 such deaths. All of these deaths were screened. None required investigation. None of these deaths were due to restraint or hold. These numbers were not included in the above table.

Private Facilities: Group Homes, Outpatient and Day Treatment facilities[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Buncombe	New Vistas Behavioral Health Services-Buncombe	1	0	
	Western Carolina Treatment Center	4	2	
Catawba	McLeod Addictive Disease Center-Hickory	1	0	
Cumberland	Cumberland County Day Reporting Center	1	0	
	My Brother's Place	1	1	
	Roxie Avenue Center	1	0	
Currituck	Highway 158-Grandy	1	0	
Davidson	Daymark Recovery Services #2	1	0	
Guilford	Lake House	1	1	
Halifax	Smith Church Rd.-Roanoke Rapids	1	0	
Henderson	Trend MH/DD/SAS	1	0	
Johnston	Day By Day Treatment Center	1	0	
Mecklenburg	Archdale-Trinity Center	1	0	
	Covenant Group Home	1	1	1
Nash	Edgecombe-Nash MH/DD/SAS	1	0	
New Hanover	Coastal Horizons Center, Inc.	3	0	
Person	Person Counseling Center	1	0	
Richmond	Sandhills Center Richmond	1	0	
Rockingham	Rockingham County Mental Health	1	0	
Stanly	Daymark Recovery Services	1	0	

Private Facilities: Group Homes, Outpatient and Day Treatment facilities[1] (Continued)

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Watauga	McLeod Addictive Disease Center-Watauga	1	0	
Total		**26**	**5**	**1**

NOTES:

1. There were 3,660 Group Homes, Outpatient & Day Treatment Facilities with a total of 14,411 beds.
2. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

As noted in the above table, one death was due to restraint/hold. The facility was cited for non-compliance with rules, a penalty was imposed, and revocation of license was issued.

A number of private group homes, outpatient & day treatment facilities voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2004 and ending June 30, 2005, 17 facilities reported 18 such deaths. Each of these reports was screened, and five were investigated. None of these deaths were due to restraint or hold. These numbers were not included in the above table.

Private Facilities: Intermediate Care Facilities for the Mentally Retarded (ICF-MR)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Madison	Blue Ridge Homes - Madison	1	0	
Pitt	SCI – East	1	1	
Total		**2**	**1**	**0**

NOTES:

1. There were 330 Private ICF-MR's with a total of 2,749 beds.
2. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

A few private ICF-MR's voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2004 and ending June 30, 2005, four facilities reported four such deaths. Each of these reports was screened, and one was investigated. None of these deaths were due to restraint or hold. These numbers were not included in the above table.

Private Facilities: Psychiatric Hospitals[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Avery	Charles A. Cannon Memorial Hospital	1	1	
Catawba	Frye Regional Medical Center	1	1	
Gaston	Gaston Memorial Hospital	1	1	
Guilford	Moses Cone Behavioral Health Care Hospital	2[3]	2[3]	

Private Facilities: Psychiatric Hospitals[1] (Continued)

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Moore	First Health of the Carolinas Moore Regional Hospital	1	0	
Pitt	Pitt County Memorial Hospital	1	1	
Wake	Holly Hill Hospital	1	1	
Total		**8**	**7**	**0**

NOTES:

1. There were 47 Private Psychiatric Hospitals and Hospitals with Psychiatric Units with a total of 1,775 beds.
2. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.
3. One of the deaths reported occurred within seven (7) days of a restraint/hold that was administered by a different facility. The death at the reporting facility was due to suicide and was not related or due to the restraint/hold.

Several private psychiatric hospitals voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2004 and ending June 30, 2005, six facilities reported twelve such deaths. Each of these reports was screened, and none were investigated. None of the deaths were due to restraint or hold. These numbers were not included in the above table.

Private Facilities: Facilities not licensed in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5

County	Facility	# Deaths Reported and Screened	# Reports Investigated[1]	# Investigated and Death was due to Restraint/Hold[2]
Alexander	Universal Mental Health	1	1	
Buncombe	New Vistas Behavioral Health	1	1	
Burke	ARP/Phoenix of Burke	2	1	
Carteret	LeChris Counseling Center	2	2	
Catawba	Catawba Valley Behavioral Health Care	2	2	
Craven	Neuse Center for Mental Health, Developmental Disabilities & Substance Abuse Services	1	1	
	Crystal Coast Therapy	1	0	
Cumberland	Cumberland County Mental Health Center	3	2	
Dare	Albemarle Mental Health Center & Developmental Disabilities & Substance Abuse Services	1	0	
Davie	Hope Ridge Center for Behavioral Health	2	1	
Durham	Telecare Durham ACTT	1	1	
Forsyth	Hope Ridge Center for Behavioral Health	1	1	
Gaston	ARP/Phoenix	1	1	
Halifax	BriteSmilz Family and Community Connections	1	1	
	Partnership for a Drug Free NC, Inc.	1	0	

Private Facilities: Facilities not licensed in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5 (Continued)

County	Facility	# Deaths Reported and Screened	# Reports Investigated[1]	# Investigated and Death was due to Restraint/Hold[2]
Henderson	Mountain Laurel Community Services	1	1	
Hoke	Sandhills Center for Mental Health, Developmental Disabilities & Substance Abuse Services	1	1	
Jackson	Meridian Jackson Outpatient Center	1	0	
Johnston	Johnston County Mental Health, Developmental Disabilities & Substance Abuse Services	3	2	
Mecklenburg	Person Centered Partnership, Inc.	1	1	
New Hanover	Southeastern Center for Mental Health, Developmental Disabilities & Substance Abuse Services	1	1	
Pasquotank	Albemarle Mental Health Center & Developmental Disabilities & Substance Abuse Services	1	0	
Person	Person Counseling Center	1	1	
Randolph	Randolph ACTT	1	1	
Roberson	Southeastern Regional Mental Health, Developmental Disabilities & Substance Abuse Services	1	1[3]	
Stokes	Hope Ridge Center for Behavioral Health	1	1	
Transylvania	Mountain Laurel Community Services	2	2	
Wake	Triumph, LLC	1	0	
	Wake County Human Services	2	1	
	Triangle Family Services	1	1	
	Area Services and Programs Inc	1	1	
Yancey	New Vistas Behavioral Health	1	1	
Total		**42**	**31**	**0**

NOTES:

1. All of the deaths annotated in this column were investigated by the responsible Local Management Entity (LME) providing oversight, and the findings were reviewed by the Division of MH/DD/SAS. One of these deaths (see Note 3) was further investigated by the Division of MH/DD/SAS.
2. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.
3. This death was investigated by the Division of MH/DD/SAS.

A number of private facilities that were not licensed voluntarily reported deaths that were not subject to G.S. 122C-31. For the period beginning July 1, 2004 and ending June 30, 2005, eight facilities reported eight such deaths. Each of these reports was screened, and one was investigated. None of the deaths were due to restraint or hold. These numbers were not included in the above table.

DEATHS REPORTED BY STATE FACILITIES

The last two tables provide data submitted by State facilities. It should be noted that death reporting for State facilities is different than for private facilities. The Secretary of DHHS has directed State-operated facilities to report all deaths to the Division of Facility Services, regardless of circumstance. This directive was first issued in April 2000 and re-issued in March 2001.

The following two tables for State facilities include all deaths, regardless of circumstances. For comparison with private facilities, summary information about the number of deaths that were subject to G.S. 122C-31 reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide) are provided below each table.

State Facilities: All Deaths Reported in State-Operated Intermediate Care Facilities for the Mentally Retarded (ICF-MR)[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Burke	J. Iverson Riddle Developmental Center	1	0	
Granville	Murdoch Center	12	2	
Lenoir	Caswell Center	24	2	
Wayne	O'Berry Center	9	0	
Total		**46**	**4**	**0**

NOTES:

1. There were 4 State-Operated ICF-MR's with a total of 2,463 beds.
2. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

The above table includes all deaths, regardless of circumstance. None of the deaths were due to restraint, physical hold, or seclusion. None of the above reported deaths were subject to G.S. 122C-31 reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide).

State Facilities: All Deaths Reported in State-Operated Psychiatric Hospitals[1]

County	Facility	# Deaths Reported and Screened	# Reports Investigated	# Investigated and Death was due to Restraint/Hold[2]
Burke	Broughton Hospital	12	3	
Granville	John Umstead Hospital	2	1	
Wake	Dorothea Dix Hospital	9	1	
Wayne	Cherry Hospital	3	0	
Total		**26**	**5**	**0**

NOTES:

1. There were 4 State-Operated Psychiatric Hospitals with a total of 1,532 beds.
2. Shading in the last column, titled "# Investigated and Death was due to Restraint/Hold," indicates that either an investigation was not warranted, or the result of the investigation indicated that the death was not due to restraint or physical hold.

The above table includes all deaths, regardless of circumstance. None of the deaths were due to restraint, physical hold, or seclusion. Four of the above reported deaths were subject to G.S. 122C-31 reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide). Two of these were reported by Broughton Hospital (one was due to homicide, and one was the result of an accident), and two were reported by Dorothea Dix Hospital (one was due to suicide, and one was the result of an accident). The remaining 22 deaths were due to other causes.

TOTAL DEATHS

In all, a total of 152 private facilities and eight State facilities reported 264 deaths for the time period beginning July 1, 2004 and ending June 30, 2005.

A total of 192 deaths were reported by private facilities. Of this number, 110 were subject to statutory reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide). The other 82 were voluntarily reported. They were due to other causes and were not subject to statutory reporting requirements.

A total of 72 deaths were reported by State facilities. Of this number, four were subject to statutory reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide), and 68 were due to other causes and were not subject to statutory reporting requirements.

All deaths that were reported were screened. Approximately one-third (29.2%) of these deaths were investigated. One of the deaths occurred within seven days of restraint, physical hold, or seclusion. However, this death was not the result of the use of restraint, physical hold, or seclusion. One death was found to be the result of the use of restraint, physical hold, or seclusion. The facility involved was cited for non-compliances with rules, a penalty was imposed, and revocation of licensure was issued.

Blank copies of the death reports used by facilities are included as **Attachment A**: **Report of Deaths** (for licensed assisted living and psychiatric inpatient facilities) and **B: Incident Death Form** (for all remaining facilities).

FACILITY COMPLIANCE WITH RESTRAINTS AND SECLUSION

Session Laws 2000-129 and 2003-80 also require the Department to report each year on facility compliance with restraint and seclusion policies. The data in this section were collected from on-site investigations, inspections and monitoring visits conducted by Department staff.

Separate tables are provided showing the number of restraint, physical hold, and seclusion related citations, by facility, for each type of facility, for the time period beginning July 1, 2004 and ending June 30, 2005. Additional data analysis is provided at the end of this section indicating the areas of highest and lowest non-compliance for each type of facility.

In reviewing the tables below, please note that the compliance data do not reflect all facilities. Rather, the data are limited to those facilities that warranted an on-site visit by Department staff. These visits include initial and change-of-ownership licensure surveys, reviews of problem-prone facilities, deficiency follow-up visits, and complaint investigations. If a facility is not listed in the following tables, a citation for non-compliance with restraint/seclusion policies was not made.

NUMBER OF RESTRAINT/SECLUSION RELATED CITATIONS

Private Facilities: Licensed Assisted Living Facilities

County	Facility	# Citations
Catawba	Crown Villa	3
Cumberland	Forest Hills Rest Home	2
Gaston	Countryside Villa	16
	Wellington House	2
Nash	Trinity Retirement Villa #2	6
Mecklenburg	The Place at Southpark	5
	Helton Manor	2
	Sunrise Eastover Assisted Living	2
Robeson	Hope Village	5
Wake	Pine Tree Villa	2
Wayne	Glen Care of Mount Olive	6
Wilson	Elm City	4
Total		**55**

Private Facilities: Group Homes, Outpatient and Day Treatment Facilities

County	Facility	# Citations
Alamance	Phoenix Bridge Group Home #2	1
	Keeana's DDA Home	1
	Angel's #4	1
Beaufort	Lots of Love 1	1
Burke	Mountain View	1
Cabarrus	Hunter's Place 2	2
Cleveland	Eastpointe Children's Home	1
Craven	Mattie Stone	1
Cumberland	Golden Opportunity for Children	2
	Strickland Bridge Rd. Treatment Facility	3
	Lafayette Home for Children	1
	Habiba Inc.	1
	Thomas S. Cambridge	2
	Soteria	3
	Thomas Bacote Center	3
	Bryant's Place	1
	Mary Rebecca Home	1
	Wings of Angels	2
	New Alternatives Adult Home	1
Davidson	Converse IRT	1
Forsyth	Addiction Recovery Care Association	1
	Independence Place	2
Gaston	Gaston-Lincoln Area MH/MR	2
	Monument Home	1
Greene	Hopewell	1
Guilford	Corregidor House	1
	Guilford Home	1
	Joyce House	1
Harnett	New Horizon Residential Treatment Facility	1

Private Facilities: Group Homes, Outpatient and Day Treatment Facilities (Continued)

County	Facility	# Citations
Haywood	Haywood County Group Home #2	1
Henderson	Emmaus	1
Hoke	Potter's House Outreach Corp.	2
Johnston	Clark Group Home	1
Lenoir	Shackleford House	1
Mecklenberg	Keith Kids	1
	Davis and Davis New Beginnings	2
	Keystone Charlotte LLC	1
	Gee-Ree BWC Training Academy 2	2
	Glory Group Home	2
	Crosswinds	2
	Covenant Group Home	1
	Covenant Group Home 1	1
	Covenant Group Home #2	4
	Connell Group Home	2
	Phoenix #4	1
	Alexander Children Center	1
	Pivot Training and Treatment Academy #1	1
	Pivot #9	1
	Promise Keeper	2
	Kids Haven	2
New Hanover	Yahweh Center Children/ Bill's Child Cottage	1
Onslow	Martha Group Home	1
Orange	Starling	1
Pitt	Progressive Provider Care #2	2
Polk	Hidden Hill	1
	Peniel #2	1
Robeson	Jones and JJ Group Home	1
Rutherford	Chrisman Adult Home	1
Surry	Hope Valley Women Division	1
Transylvania	Transylvania Assoc. For Disabled Citizens	2
Union	Lasalle	1
	Easter Seal UPC Union County Group Home	3
	Griffith Road Home	2
	Richardson Street Home	2
Vance	Rice Family Care Home	2
	Lynn Bank Road Home	1
Wake	Holly Brooks Care Facility	1
	Lenoir Place	1
	Dutch Gardens Family Group Home	2
	Serenity Care Place V	1
	Willow Bend	1
Watauga	New River Respite	1
	New River Vocational Center	2
Wilson	Youth Service Inc. II	1
	Dartmore Home	1
Total		**107**

Private Facilities: Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

County	Facility	# Citations
Alamance	RSL-Poplar Street	1
Lee	TLC	1
Richmond	Mallard Lane	2
	Pence Place	1
Total		**5**

Private Facilities: Psychiatric Inpatient Facilities

County	Facility	# Citations
Avery	Charles A. Cannon Memorial Hospital	2
Buncombe	Mission/St. Josephs Memorial Hospital	3
Catawba	Catawba Valley Medical Center	1
Cleveland	Kings Mountain Hospital	1
Henderson	Park Ridge Hospital	5
Mecklenburg	Carolinas Medical Center	1
	Presbyterian Hospital	5
Onslow	Brynn Marr Behavioral Health	1
Stanley	Stanley Memorial Hospital	6
Total		**25**

The number of restraint/seclusion related citations for psychiatric inpatient facilities was lower for the period 7/1/04 – 6/30/05 than for the prior state fiscal year. This may be the result of fewer annual state licensure surveys being conducted this year as staff resources were shifted to conducting complaint investigations, the majority of which involved other issues.

Private Facilities: Federal Psychiatric Residential Treatment Facilities (PRTF)/ State Intensive Residential Treatment for Children or Adolescents

County	Facility	# Citations
Forsyth	Old Vineyard Youth Services	Federal: 5
Mecklenburg	Alexander Children's Center	State: 3 Federal: 9
Onslow	Brynn Marr Behavioral Health	Federal: 5
Total		**22**

Federal Psychiatric Residential Treatment Facilities are a special category of facilities that are subject to more stringent federal standards governing the use of restrictive interventions. The above table reflects the number of citations that were issued to these facilities by both state and federal reviewers for non-compliance with restraint and seclusion requirements.

Private Facilities: Facilities not licensed in accordance with G.S. 122C, Article 2 and not State facilities operating in accordance with G.S. 122C Article 4, Part 5

County	Facility	# Citations
	No restraint/seclusion related citations were issued	0
Total		**0**

State Facilities: State-Operated Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

County	Facility	# Citations
	No restraint/seclusion related citations were issued	0
Total		**0**

State Facilities: State-Operated Psychiatric Hospitals

County	Facility	# Citations
Granville	John Umstead Hospital	4
Total		**4**

A total of 103 private facilities and one State-operated facilities were cited for non-compliance with one or more restraint/seclusion regulations for the time period beginning July 1, 2004 and ending June 30, 2005.

MOST AND LEAST FREQUENT AREAS OF RESTRAINT/SECLUSION NON-COMPLIANCE

The following table provides an analysis of the most and least frequent areas of restraint/ seclusion non-compliance. Percentages represent the percent of all citations for that type of facility. Caution should be exercised when comparing percentages across different facility types. It should be noted that percentages for some types of facilities will be a large number when in fact there may have been a low number of non-compliances cited. For example, in the case of State-Operated Psychiatric Hospitals, there were a total of four (4) citations issued. A single citation equates to 25% of the total. In contrast, in the case of Private Group Homes, Outpatient and Day Treatment Facilities, there were a total of 107 citations issued. In this case, a single citation equates to 0.9% of the total.

Facility Type	Areas of Restraint/Seclusion Non-Compliance	
	Most Frequent	**Least Frequent**
Licensed Assisted Living Facilities	• Inappropriate use of restraints (61%) • Lack of appropriate training (29%) • Inadequate assessment and care planning (11%)	• Inadequate restraint orders (4%) • Failure to assure resident or legal representative accepts or refuses restraint use (10%)
Group Homes, Outpatient and Day Treatment Facilities	• Failure to receive any training and/or to demonstrate competencies in restrictive interventions (32%) • Failure to receive any training and/or to demonstrate competencies on alternatives to restrictive intervention (25%) • Failure to receive annual training on alternatives to	• Failure to assure physical restraints were used only in an emergency situation (1%) • Failure to assure staff did not use a restrictive intervention as a means of punishment (1%) • Failure to develop and implement policies and procedures on the use of alternatives to restrictive interventions (1%)

Facility Type	Areas of Non-Compliance (Continued)	
	Most Frequent	**Least Frequent**
	restrictive interventions (12%) • Failure to receive annual training on restrictive interventions (11%)	• Failure to immediately discontinue the restrictive intervention at any indication to the client's health and safety (1%) • Failure to document staff training in restrictive interventions (1%)
Private ICF-MR's	• Failure to maintain an accurate record of restraint (60%)	• Failure to provide 30 minute checks (20%) • Failure to release person from restraint as soon as possible (20%)
Private Psychiatric Inpatient Facilities	• Inadequate restraint or seclusion monitoring (28%) • Inadequate restraint or seclusion documentation (24%) • Inadequate training in restrictive interventions (16%) • Inadequate restraint and seclusion policy and procedures (12%)	• Restraints or seclusion not ordered properly (8%) • Inadequate notification of guardian regarding restraint or seclusion (4%) • Inadequate restraint and seclusion room (4%) • Failure to modify treatment plan (4%)
Federal PRTF/ State Intensive Residential Treatment for Children or Adolescents	• Inadequate restraint or seclusion documentation (47%) • Restraint or seclusion not ordered properly (13%) • Administration non-compliance with restraint and seclusion Attestation letter (13%)	• Failure to modify treatment plan (9%) • Inadequate training in restrictive interventions (9%) • Inadequate restraint or seclusion monitoring (5%) • Inadequate restraint and/or seclusion policy and procedures (5%)
State Psychiatric Inpatient Facilities	• None in this category (none of the citations that were issued were listed more than once)	• Restraint or seclusion not ordered properly (25%) • Lack of face-to-face assessment within one hour of restraint (25%) • Inadequate restraint or seclusion monitoring (25%) • Inadequate restraint or seclusion documentation (25%)

SUMMARY

In all, a total of 152 private facilities (112 licensed and 40 unlicensed facilities) and eight State facilities reported one or more deaths for the time period beginning July 1, 2004 and ending June 30, 2005. This represents 2.25% of the 5,332 licensed private facilities and 100% of the eight State facilities.

A total of 192 deaths were reported by private facilities. Of this number, 110 deaths were subject to statutory reporting requirements (e.g. occurred within seven days of restraint, physical hold, or seclusion, or were the result of violence, accident, suicide, or homicide). The other 82 deaths were voluntarily reported. They were due to other causes and were not subject to statutory reporting requirements.

A total of 72 deaths were reported by State facilities. Of this number, four were subject to statutory reporting requirements, and 68 were not subject to statutory reporting requirements.

All deaths that were reported were screened. Approximately one-third (29.2%) of these deaths were investigated. One death occurred within seven days of restraint, physical hold, or seclusion. However, this death was not the result of restraint, physical hold, or seclusion. One death was found to be the result of restraint, physical hold, or seclusion. The facility involved was cited for non-compliances with rules, a penalty was imposed, and revocation of licensure was issued.

In all, a total of 103 licensed private facilities and one State-operated facility were cited for non-compliance with one or more restraint/seclusion regulations during this same time period. This represents approximately two percent (1.9%) of the 5,332 licensed private facilities and 12.5% of the eight State-operated facilities. It should be noted that the compliance data do not reflect all facilities. Rather, the data are limited to those facilities that warranted an on-site visit by Department staff. These visits included initial and change-of-ownership licensure surveys, reviews of problem-prone facilities, deficiency follow-up visits, and complaint investigations. A total of 1,804 licensure surveys and reviews of problem-prone facilities were conducted. In addition, 271 deficiency follow-up visits and 506 complaint investigations were conducted.

A total of 65 complaint investigations involving unlicensed facilities were conducted during this period. None of these complaints were related to the use of restraint/seclusion, and no citations related to the use of restraint/seclusion were issued.

For those facilities that were cited for non-compliance, citations covered a wide range of areas from inadequate policies and procedures, documentation, training, and demonstration of skills and competencies, to inappropriate use of restrictive intervention, inadequate monitoring, and failure to release the consumer from restraint as soon as possible or at any indication of adverse effect on the consumer's health and safety.

Attachment A

REPORT OF DEATH TO DHHS

All requested information must be provided. This form is for reporting deaths for all facilities operating under G.S. 122C and psychiatric units of hospitals licensed under G.S. 131E. All deaths related to use of seclusion or restraint, accidents, homicides, suicides or violence must be reported. If any requested information is unavailable, provide an explanation. The information must be provided immediately upon its availability. ■ *If additional space is needed,* attach separate sheets, referencing the part of the form to which the information pertains. ■ You may include additional information that you consider helpful, such as client assessments and discharge summaries. ■ **(Please Note: Facilities are encouraged to keep a copy of the report for their records)**

***Send or fax form to*: Licensed facilities - Chief, Mental Health Licensure & Certification Section, Division of Facility Services, 2718 Mail Service Center, Raleigh, NC 27699-2718. Fax: (919) 715-8077; Phone: (919) 855-3795.**
Unlicensed facilities – Chief, Program Accountability Section, DMH/DD/SAS, 3012 Mail Service Center, Raleigh, NC 27699. Fax: (919) 881-2451; Phone (919) 881-2446.

Section I: Reporting Facility

Name of reporting facility:	Medicare/Medicaid Provider # (if applicable):	Facility director:	Telephone:
Address:	License # (if applicable):	First person to discover decedent:	Staff first receiving report of decedent's death:
	County:	Person (including title) preparing report:	Date/Time report prepared:

Section 2: Client Information

Name of decedent:	Client Record No:	Unit/Ward (if applicable):	
	Medicare/Medicaid No:	Date of Birth:	Age:
Admitting diagnoses:	Adjudicated incompetent: ☐ Yes ☐ No	Weight (if known):	Race:
	Date(s) of last two (2) medical exams (if known):	Height (if known):	Sex:

Date of most recent admission to a State operated psychiatric, developmental disability or substance abuse facility (if known):	Date of most recent admission to an acute care hospital for physical illness (if known):
Primary/secondary mental illness, developmental disability, or substance abuse diagnosis:	Primary/secondary physical illness/conditions diagnosed prior to death:

Section 3: Circumstances of Death

Place where decedent died:	Date and time death was discovered:	
Address:	Physical location decedent was found:	
	Cause of death (if known):	
Was decedent "restrained" at the time of death or within 7 days of death? ☐ Yes ☐ No If "yes," describe type and usage:	Was decedent in "seclusion" at the time of death or within 7 days of death? ☐ Yes ☐ No If "yes," describe:	
Describe events surrounding the death:		

Section 4: Other Information

Please list other authorities (such as law enforcement or the County Department of Social Services) that have been notified, have investigated or are in the process of investigating the death or events related to the death:

North Carolina Department of Health & Human Services – Division of Mental Health/Developmental Disabilities/Substance Abuse Services

CONFIDENTIAL DHHS Incident and Death Report *CONFIDENTIAL*

Provider Agency Name _____ Consumer's Name _____ Consumer's Social Security No. ___ - ___ - ____

This form is used to report Level II and Level III incidents, including deaths and restrictive interventions, involving any person receiving publicly funded mental health, developmental disabilities and/or substance abuse (MH/DD/SA) services. Facilities licensed under G.S. 122C (except hospitals) and unlicensed providers of community-based MH/DD/SA services must submit the form, as required by North Carolina Administrative Code 10A NCAC 27G .0600, 26C .0300, and 27E .0104(e)(18). Failure to complete this form may result in administrative actions against the provider's license and/or authorization to receive public funding. This form may also be used for internal documentation of Level I incidents, if required by provider policy or LME contract. Effective October 1, 2004, this form replaces the *Critical Incident and Death Reporting Form (Form QM01)* and the *Report of Death to DHHS*.

***Instructions*: Complete and submit this form to the local and/or state agencies responsible for oversight within 72 hours of learning of the incident (See page 3 for details). Report deaths of consumers that occur within 7 days of restraint or seclusion immediately.**
If requested information is unavailable, provide an explanation on the form and report the additional information as soon as possible.
***Page 1-2 Instructions*: The staff person who is most knowledgeable about the incident should complete pages 1-2 of this form as soon as possible after learning of the incident and submit to the unit supervisor for review and approval.**

Date of Incident: _____ **Time of Incident**: _____ ☐ a.m. ☐ p.m. ☐ Unknown

CONSUMER INFORMATION

Consumer's Date of Birth: _____ **Consumer's Gender**: ☐ Male ☐ Female

All Diagnoses: _____ **Consumer's Ethnicity** (*Check all that apply*):

☐ Hispanic/Latino ☐ Native American ☐ Asian/Pacific Islander
☐ White/Anglo ☐ Black/African American ☐ Other *(specify)*: _____

Does consumer receive CAP/MR-DD Waiver services? ☐ Yes ☐ No ☐ Unknown

DESCRIPTION OF INCIDENT

LOCATION OF INCIDENT

☐ Provider premises
☐ Consumer's legal residence
☐ Community
☐ Other *(specify)*
_____
(such as hospital, state institution, etc.)
☐ Unknown

OTHER PEOPLE INVOLVED *(Provide name of person and their relationship to the consumer who is the subject of the report)*	Other Consumer	Staff	Other
1.	☐	☐	☐
2.	☐	☐	☐
3.	☐	☐	☐
4.	☐	☐	☐
5.	☐	☐	☐

Name / title of first staff person to learn of incident _____

Was the consumer under the care of the reporting provider at the time of the incident? ☐ Yes ☐ No

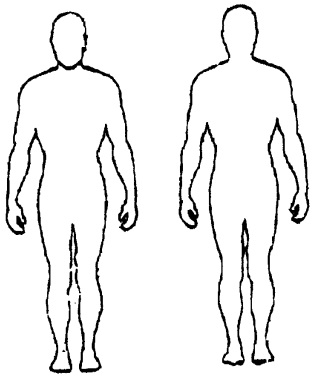
Was the consumer treated by a licensed health care professional for the incident? ☐ Yes ☐ No Date: _____

Was the consumer hospitalized for the incident? ☐ Yes ☐ No Date: _____

Describe the incident, including Who, What, When, Where, and How. *(Describe any preceding circumstances, resulting harm to people, property damage, and any other relevant information. Attach additional pages if needed.)*

INJURY

On the figures below, circle the location of any bruises, cuts, scratches, injuries, or other marks that occurred as a result of the incident.



FRONT BACK

NOTE: Incident reports are confidential quality assurance documents, protected by GS 122C-30, 122C-31, 122C-191 and 122C-192. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164.

CONFIDENTIAL DHHS Incident and Death Report *CONFIDENTIAL*

Provider Agency Name _____ Consumer's Name _____ Consumer's Social Security No. ___ - ___ - ____

TYPE OF INCIDENT

CONSUMER DEATH

Death due to: ☐ SUICIDE ☐ ACCIDENT ☐ HOMICIDE / VIOLENCE ☐ Terminal illness / natural cause ☐ Unknown cause

Did death occur within 7 days of the restrictive intervention? ☐ Yes ☐ No ***If yes, immediately submit this form to your supervisor.***

DETAILS OF DEATH REPORTABLE TO NC DEPARTMENT OF HEALTH & HUMAN SERVICES

Complete this section only for deaths from suicide, accident, or homicide/violence or occurring within 7 days of restrictive intervention.

Address where consumer died: _____

Physical illnesses / conditions diagnosed prior to death: _____

Dates of last two (2) medical exams: _____ _____ ☐ Unknown ☐ None

Date of most recent admission to a hospital for physical illness: _____ ☐ Unknown ☐ None

Date of most recent admission to an inpatient MH/DD/SAS facility: _____ ☐ Unknown ☐ None

Height: ____ ft ____ in ☐ Unknown **Weight**: _____ lbs ☐ Unknown **Adjudicated incompetent?** ☐ Yes ☐ No

RESTRICTIVE INTERVENTION

(Number in order of use)

____ Physical Restraint

____ Isolation

____ Seclusion

Is the use of restrictive intervention part of the consumer's Individual Service Plan? ☐ Yes ☐ No

Was the restrictive intervention administered appropriately? ☐ Yes ☐ No

Did the use of restrictive intervention(s) result in discomfort, complaint, or require treatment by a licensed health professional? ☐ Yes ☐ No

Attach a Restrictive Intervention Details Report (Form QM03) or a provider agency form with comparable information.

OTHER INCIDENT

INJURY

Report injuries requiring treatment by a licensed health professional

(Check only one)

Injury due to:

☐ Aggressive behavior

☐ Self-mutilation

☐ Trip or fall

☐ Auto accident

☐ Other (specify) _____

ABUSE ALLEGATION

(Check all that apply)

☐ Alleged abuse of a consumer

☐ Alleged neglect of a consumer

☐ Alleged exploitation of a consumer

Report any alleged or suspected case of abuse, neglect or exploitation of a consumer, as required by law, to the county Dept. of Social Services and the DFS Healthcare Personnel Registry, as well as the host LME.

MEDICATION ERROR

Report errors that threaten health or safety

(Check only one)

☐ Wrong dosage administered

☐ Wrong medication administered

☐ Wrong time *(administered more than one hour from prescribed time)*

☐ Missed dosage *(including refusals)*

CONSUMER BEHAVIOR

(Check only one)

☐ Suicide attempt

Report the following whenever a report to legal authorities is made:

☐ Inappropriate or illegal sexual behavior

☐ Illegal acts by a consumer

☐ Other consumer behavior

OTHER INCIDENT

(Check only one)

☐ Suspension of a consumer from services [*Enter number of days* ____]

☐ Expulsion of a consumer from services

☐ Fire that threatens or impairs a consumer's health or safety

☐ Unplanned consumer absence more than 3 hours over time allowed or absence reported to legal authorities *(where absence is restricted by the service plan)*

Name/title of staff person documenting incident *(Please print)*: _____ Phone (____) _____

Signature _____ Date _____ Time _____ ☐ a.m. ☐ p.m.

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CONFIDENTIAL DHHS Incident and Death Report *CONFIDENTIAL*

Provider Agency Name _____ Consumer's Name _____ Consumer's Social Security No. ___ - ___ - ____

***Page 3 Instructions*: The supervisor of the service should review pages 1-2 of this form, complete page 3 and submit to required agencies in the required timeframes. Use Criteria on page 5 to determine the level of incident. Refer to the Incident Response Manual for further details.**

PROVIDER INFORMATION

Facility / Unit _____ **Facility /Unit Director**: _____

Service address: _____ **City**: _____ **County** _____

Facility /Unit Phone Number: ( ) _____ **Provider Tax ID or Social Security No.**: _____

Service being provided at time of incident: ☐ Residential ☐ Non-residential (*specify)* _____ ☐ N/A

122C-Licensed service? ☐ No ☐ Yes *(License No.)* _____ ***If yes, note reporting instructions for Level III below.***

LEVEL OF INCIDENT

☐ **Level II (Moderate)**

Send this form to the host LME (LME responsible for geographic area where service is provided) within 72 hours. If required by contract, also report to the consumer's home LME if different.

☐ **Level III (High)**

Immediately report verbally to the host LME. Convene an incident review committee within 24 hours if services were being actively provided at time of incident. (See manual for details.) Send this form within 72 hours to:

- *host LME (see bottom of page)*
- *consumer's home LME*
- *NC Division of MH/DD/SAS, Quality Management Team, 3004 MSC, Raleigh, NC 27699-3004. Voice: (919) 733-0696, Fax: (919) 715-3604*

NOTE: *Report deaths that occur within 7 days of seclusion or restraint immediately.*

NOTE: *If the service is licensed under G.S.122C, also use the same deadlines to report death from suicide, accident, or homicide/violence and deaths occurring within 7 days of restraint or seclusion, to the NC Division of Facility Services, Complaint Intake Unit, 2711 MSC, Raleigh, NC 27699-2711 Voice: 1-800-624-3004 Fax: 1-919-715-7724*

PROVIDER RESPONSE

Describe the cause of the incident *(attach additional pages if needed)*:

Describe how this type of incident may be prevented in the future and any corrective measures that have been or will be put in place as a result of the incident *(attach additional pages if needed)*:

REPORTING INFORMATION

Indicate authorities or persons notified of the incident *(as applicable)*:

Agency / Person	Contact Name	Phone	Notification Date
☐ Host LME _____		( )	
☐ Home LME _____		( )	
☐ Law enforcement		( )	
☐ County DSS _____		( )	
☐ Health Care Personnel Registry		( )	
☐ Service Plan Team		( )	
☐ Parent / Guardian		( )	
☐ NC DMH/DD/SAS		( )	
☐ NC DFS Complaint Unit		( )	
☐ Other _____		( )	

Name/title of supervisor authorizing report *(Please print)*: _____ Phone ( ) _____

Signature _____ Date _____ Time _____ ☐ a.m. ☐ p.m.

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CONFIDENTIAL **DHHS Incident and Death Report** *CONFIDENTIAL*

Provider Agency Name _____ Consumer's Name _____ Consumer's Social Security No. ___ - ___ - _____

Page 4 Instructions: ***This page is available for the provider agency or any agencies receiving the report to use for internal tracking and follow-up purposes. Leave this page blank when sending an incident report to the LME and/or other agencies..***

INCIDENT TRACKING ***(for internal use only)***

INTERNAL USE ONLY

Incident Report Receipt Date: _____

Current Consumer Status:

LME's (or Other Oversight Agency's) Response:

Name/title of follow-up staff person *(Please print)*:

_____ Phone (____) _____

Signature _____ Date _____ Time _____ ☐ a.m. ☐ p.m.

INTERNAL USE ONLY

Notes:

NOTE: Incident reports are confidential quality assurance documents, protected by GS 122C-30, 122C-31, 122C-191 and 122C-192. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected under Federal regulations, 42 CFR Part 2 and HIPAA, 45 CFR Parts 160 and 164.

DHHS Criteria for Determining Level of Response to Incidents

Incidents are events that are inconsistent with the routine operation of a service or care of a consumer that are likely to lead to adverse effects. Providers must report incidents, as defined below, that occur while a consumer is under their care. Individuals receiving residential and ACT Team services are considered under the provider's care 24 hours a day. Individuals receiving day services and periodic services are considered under the provider's care while a staff person is actively engaged in providing a service. See Manual for details.

	EVENT	LEVEL I	LEVEL II	LEVEL III[1]	EXCEPTIONS
CONSUMER DEATH	Consumer Death	----------	Due to: - Terminal illness or other natural cause - Unknown cause	Due to: - Suicide - Violence / homicide - Accident Or occurring: - Within 7 days of seclusion or restraint	• Providers of non-residential services should report as soon as they learn of death. • Review of Level III incidents within 24 hours needed only if actively engaged in providing service at time of death.
RESTRICTIVE INTERVENTION	Seclusion Isolated time-out Restraint	Any planned use administered appropriately and without discomfort, complaint, or injury[2]	1. Any emergency, unplanned use OR 2. Any planned use that exceeds authorized limits, is administered by an unauthorized person, results in discomfort or complaint, or requires treatment by a licensed health professional	Any restrictive intervention that results in permanent physical or psychological impairment within 7 days	Providers will submit aggregate numbers of Level I restrictive interventions to the host LME quarterly.[2]
CONSUMER INJURY	Due to: - Aggressive behavior - Self-harm - Trip or fall - Auto accident - Other / unknown cause	Any injury that requires only first aid, as defined by OSHA guidelines[2] *(regardless of who provides the treatment)*	Any injury that requires treatment by a licensed health professional *(such as MD, RN, or LPN)* beyond first aid, as defined by OSHA guidelines[2]	Any injury that results in permanent physical or psychological impairment	Providers of non-residential services should report Level II incidents only if actively engaged in providing service at time of incident
ABUSE	Abuse of consumer Neglect of consumer Exploitation of consumer	----------	Any allegation of abuse, neglect or exploitation of consumer by staff or other adult, including inappropriate touching or sexual behavior	Any allegation of abuse, neglect or exploitation of consumer that involves permanent physical or psychological impairment, or arrest	• Providers of non-residential services should report as soon as they learn of allegation. • Review of Level III incidents within 24 hours needed only if actively engaged in providing service at time of alleged incident.
MED ERROR	Wrong dose Wrong medication Wrong time (over 1 hour from prescribed time) Missed dose or medication refusal	Any error that does not threaten the consumer's health or safety *(as determined by the physician or pharmacist notified of the error)*	Any error that threatens the consumer's health or safety *(as determined by the physician or pharmacist notified of the error)*	Any error that results in permanent physical or psychological impairment	• Providers of periodic services should report errors for consumers who self-administer medications as soon as learning of the incident. • Review of Level III incidents within 24 hours needed only if actively providing service at time of incident. • All providers will submit aggregate numbers of Level I medication errors to the host LME quarterly.[2]
		NOTE: Report all drug administration errors and adverse drug reactions to a physician or pharmacist immediately, as required by 10A NCAC 27G .0209(h).			

[1] Providers should notify the host and home LMEs by phone upon learning of any Level III incident, even if not actively providing service at the time of the incident.
[2] See Manual for details.
NOTE: Incident reports are quality assurance documents. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected. Use the form according to confidentiality requirements in NC General Statutes and Administrative Code and the Code of Federal Regulations.

DHHS Criteria for Determining Level of Response to Incidents

	EVENT	LEVEL I	LEVEL II	LEVEL III[1]	EXCEPTIONS
CONSUMER BEHAVIOR	Suicidal behavior	Any suicidal threat or verbalization that indicates new, different or increased behavior	Any suicide attempt	Any suicide attempt that results in permanent physical or psychological impairment	Do not report previous suicide attempts by persons seeking services through the LME Access unit or for whom inpatient commitment is being sought.
	Sexual behavior	Inappropriate sexual behavior that does not involve a report to law enforcement or complaint to an oversight agency	Any sexual behavior that involves a report to law enforcement, a complaint to an oversight agency, or a potentially serious threat to the health or safety of self or others	Any sexual behavior that results in death, permanent physical or psychological impairment, arrest of the consumer, or public scrutiny *(as determined by the host LME)*	----------
	Consumer act	Any aggressive or destructive act that does not involve a report to law enforcement or complaint to an oversight agency	Any aggressive or destructive act that involves a report to law enforcement, a complaint to an oversight agency, or a potentially serious threat to the health or safety of self or others	Any aggressive or destructive act reported to law enforcement or an oversight agency that results in death, permanent physical or psychological impairment, or public scrutiny *(as determined by the host LME)*	----------
	Consumer absence	Any absence of 0 to 3 hours over the time specified in the service plan, if police contact is not required	Any absence greater than 3 hours over the time specified in the individual's service plan or any absence that requires police contact	----------	Report absences of competent adult consumers receiving non-residential services <u>only</u> if police contact is required.
OTHER	Suspension from services Expulsion from services	Any provider withdrawal of services for less than one day for consumer misconduct	Any provider withdrawal of services for one day or more for consumer misconduct	----------	----------
	Fire	Any fire with no threat to the health or safety of consumers or others	Any fires that threatens the health or safety of consumers or others	Any fire that results in permanent physical or psychological impairment or public scrutiny *(as determined by the host LME)*	----------
	Search and seizure	Any	----------	----------	All providers will submit aggregate numbers of searches and seizures to the host LME quarterly.[2]
	Confidentiality breach	Any	----------	----------	----------

***<u>Direct questions to</u>**: ContactDMHQuality@ncmail.net Phone: (919) 733-0696*

[1] Providers should notify the host and home LMEs by phone upon learning of any Level III incident, even if not actively providing service at the time of the incident.
[2] See Manual for details.

<u>NOTE</u>: Incident reports are quality assurance documents. Do not file incident reports in the consumer's service record. Confidentiality of consumer information is protected. Use the form according to confidentiality requirements in NC General Statutes and Administrative Code and the Code of Federal Regulations.